DOCUMENT RESUME

ED 261 005 SP 025 923

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TITLE Health Status and Leisure Behavior of Sexual Assault Victims: Educational Opportunities for Health and Leisure Professionals.
PUB DATE Jan 85
NOTE 14p.; Paper presented at the Annual Meeting of the Southwest Educational Research Association (Austin, TX, January 31-February 2, 1985).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Disease Incidence; *Leisure Time; Life Style; *Rape; *Victims of Crime

ABSTRACT

The health status and leisure behavior of victims of sexual assault were studied. Data concerning present illness symptoms, past illness symptoms, negative health behavior, family health history, and female reproductive physiology illness symptoms were obtained and analyzed. Sexual assault victims were similar to nonvictims demographically except that victims had more children and visited their doctors more frequently. Victims also suffered more illness symptoms, including asthma, severe colds, and stiff muscles and joints. Victims also had more negative health behaviors, such as lack of exercise, smoking, and alcohol excess, and more female reproductive illness symptoms, such as dysmenorrhea. No difference was found between victims and nonvictims regarding family health history and past illness symptoms. An association between leisure behavior and degree of reorganization or disorganization exhibited by the victim was discovered. Leisure behavior appears to play a part in successful reorganization of assault victims. (CB)

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HEALTH STATUS AND LEISURE BEHAVIOR OF SEXUAL ASSAULT VICTIMS:

Educational Opportunities for Health and Leisure Professionals

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1985 Meeting of the
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HEALTH STATUS AND LEISURE BEHAVIOR OF SEXUAL ASSAULT VICTIMS: EDUCATIONAL OPPORTUNITIES FOR HEALTH AND LEISURE PROFESSIONALS

At any time we are vulnerable to potentially catastrophic events. Catastrophies are defined as unexpected events that vary in duration and degree of physical and human destruction. Regardless of age, gender, socioeconomic status, ethnic group, or geographic locale, anyone can become a victim of a traumatic event.

In the past, catastrophic events were viewed predominantly as unpredictable "acts of God" that subjected varying sized groups to destruction of property or death (McGoargle, 1964). Investigators usually focused upon the health effects of a disaster during the immediate period of recovery from it (Logue, et. al., 1981).

Individuals who suffer as a result of catastrophic events and their consequences are considered "victims." Concern with the status of "victims" is a comparably recent development. Systematic study only began approximately 30 years ago and little research into the actual emotional consequences of disaster is available. Therefore, this exploratory study was designed to determine if victims of sexual assault differed from nonvictims on several dimensions of perceived health status. Additionally, the leisure behavior of adapting and maladapting sexual assault victims was compared.

It has been calculated that some type of rape is reported every eight to ten minutes in the United States (Federal Bureau of Investigation, 1977). Further, it is estimated that only one-fifth of the sexual assaults committed are reported (Harmatz and Novak, 1983). Although crimes are typically episodic in nature, the aftermath that "victims" suffer may continue. For the moment, we have no real idea how long they continue or even exactly what

the consequences are. Although various researchers have examined the physiological and psychological effects of sexual assault, there has been little research into post-rape behavior of rape victims. Burgess and Holmstrom (1974) studied the long term effects of sexual assault and described the"rape trauma syndrome." Rape trauma syndrome is a two phase phenomena. The acute phase, immediately following the sexual assault is characterized by physical symptoms and an attitude of fear. The reorganization phase follows the acute response as the victim attempts to stabilize and reorganize her life. The reorganization phase is often characterized by changes in motor activity, nightmares, and phobias. Four years after the assault, Burgess and Holmstrom (1979) found that a large portion of the original assault group had failed to recover.

Our investigation was conducted during October, November and December, 1983 and January, 1984. Subjects were drawn from the cities of Houston, Texas and Charleston, South Carolina.

Of the subjects who participated, 51 were victims of sexual assault and 85 were nonvictims. After subjects were matched on the variable of age, the data yield was derived from 102 respondents, 51 of which were assault victims and 51 of which were nonvictims. Data were generated from subjects' responses to a two-part instrument. Part I was the demographic questionnaire involving the variables of age, yearly income, marital status, number of children, years completed in school, visits made to the doctor per year and physical health status over the last ten years. Part II was the Cornell Medical Index Health Questionnaire which was divided into five categories, each serving as separate dependent variables. Category one were responses relating to present illness symptoms, category two were responses relating to past illness symptoms, category three related to

negative health behaviors, category four related to family health history, and category five were responses relating to female reproductive physiology illness symptoms. Treatment of the data was performed implementing: (A) Comparison tables, using means and standard deviations or percentages to analyze the demographic data. (B) A priori comparisons were conducted for each of the five categories within the Cornell Medical Index Health Questionnaire (CMI). The .01 level was selected for statistical significance. The major findings were: (1) Sexual assault victims were similar demographically to nonvictims with two exceptions: They had more children and they made more visits to the doctor per year. (2) Sexual assault victims responded more frequently to questions related to present illness symptoms. Included in present illness symptoms were conditions such as asthma, frequent, severe colds and stiff muscles and joints. (3) Sexual assault victims responded more frequently to questions related to negative health behaviors. (Lack of exercise, smoking and alcohol excesses) (4) Sexual assault victims responded more frequently to female reproductive system illness symptoms such as vaginal discharge and dysmenorrhea. (5) No difference was found between victims and nonvictims regarding family health history and past illness symptoms.

Note: Table 1 follows the references.

In a subsequent analysis the postrape leisure choices of the sexual assault victims were examined. Responses on Part II, the CMI, were subdivided into three categories. Past and present illness symptoms were grouped into category one. Categories two and three dealt with personal and social leisure behavior. Comparisons were made between the leisure behavior of adapting and maladapting sexual assault victims. It was hypothesized that (1) the personal leisure behavior of reorganized sexual assault victims would be different from that of disorganized sexual assault victims, and that (2) the social leisure

choices of reorganized victims would be different than those of disorganized victims.

The women were categorized into reorganized and disorganized groups. Assault victims were categorized as well, or reorganized, if they were statistically similar to a control group of non-victims (assault victims' overall CMI score had to fall within one standard deviation of the non-victims' mean CMI score). Since age is closely related to physical health, the researchers controlled for that variable. A total of 51 sexual assault victims participated in the investigation.

Demographically the disorganized and reorganized sexual assault victims participating in this study were similar. Statistical comparisons of the two groups on the present and past illness symptoms; as well as personal and social leisure behavior, are presented in Table 2.

Table 2 follows references.

The disorganized sexual assault victims' average indicated that they exhibited more than twice as many of the present illness symptoms subcategory of the CMI. Symptoms in this category include colds, headaches, stomach pains and elevated blood pressure. However, when past illness symptoms such as accidents, operations, and chronic illness history were compared, no significant differences were found between the two groups. In both cases, the percentage of past illness symptoms reported was small.

The personal leisure category consisted of questions regarding the time and inclination to exercise, rest, and relax. The questions were presented in reverse so a positive response indicated a negative approach to the personal leisure variable. The mean score of the disorganized assault victims was significantly higher ($p < .0001$) than the mean score of the reorganized victims.

The social leisure category was comprised of questions regarding the assault victims' time and inclination to go out and/or see friends. Obvious differences ($p < .001$) were found between the two groups. The disorganized

sexual assault victims were more likely to respond positively to negatively phrased questions relating to social leisure behavior.

There is a clear association between leisure behavior and the degree of reorganization or disorganization exhibited by the assault victim. The successfully reorganized sexual assault victims are more inclined to take time for exercise, rest, and relaxation than are their less well adapted counterparts. Additionally, the more disorganized victims are less inclined to find time to see friends and go out. Such an association, of course, does not tell the direction of causation. One possibility is that the victims with well developed personal and social leisure behaviors are better equipped to cope with the after effects of sexual assault. The other possibility is that the victims do not have different leisure behaviors prior to the sexual assault and the degree to which the victim successfully reorganizes her life reflects postrape leisure behavior. Regardless, leisure behavior does appear to be a functional part of the successful reorganization of sexual assault victims.

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Table 1

Mean Score Comparisons on Cornell Medical Index for Assault Victims and Nonvictims

Item	Assault Status			
	Victims	Nonvictims	t	P
N	51	51		
Present Illness Symptoms				
$\bar{X}$	20.15	11.98	5.51*	.01
SD	8.05	6.90		
Past Illness Symptoms				
$\bar{X}$	3.27	2.82	0.75	NS
SD	2.21	3.67		
Negative Health Behaviors				
$\bar{X}$	2.37	1.12	5.05*	.01
SD	1.42	0.99		
Family Health History				
$\bar{X}$	1.67	1.59	0.35	NS
SD	0.97	1.25		
Female Reproductive Physiology Illness Symptoms				
$\bar{X}$	4.67	2.25	6.20*	.01
SD	2.13	1.78		

$\bar{X}$ = mean

SD = standard deviation

Table 2

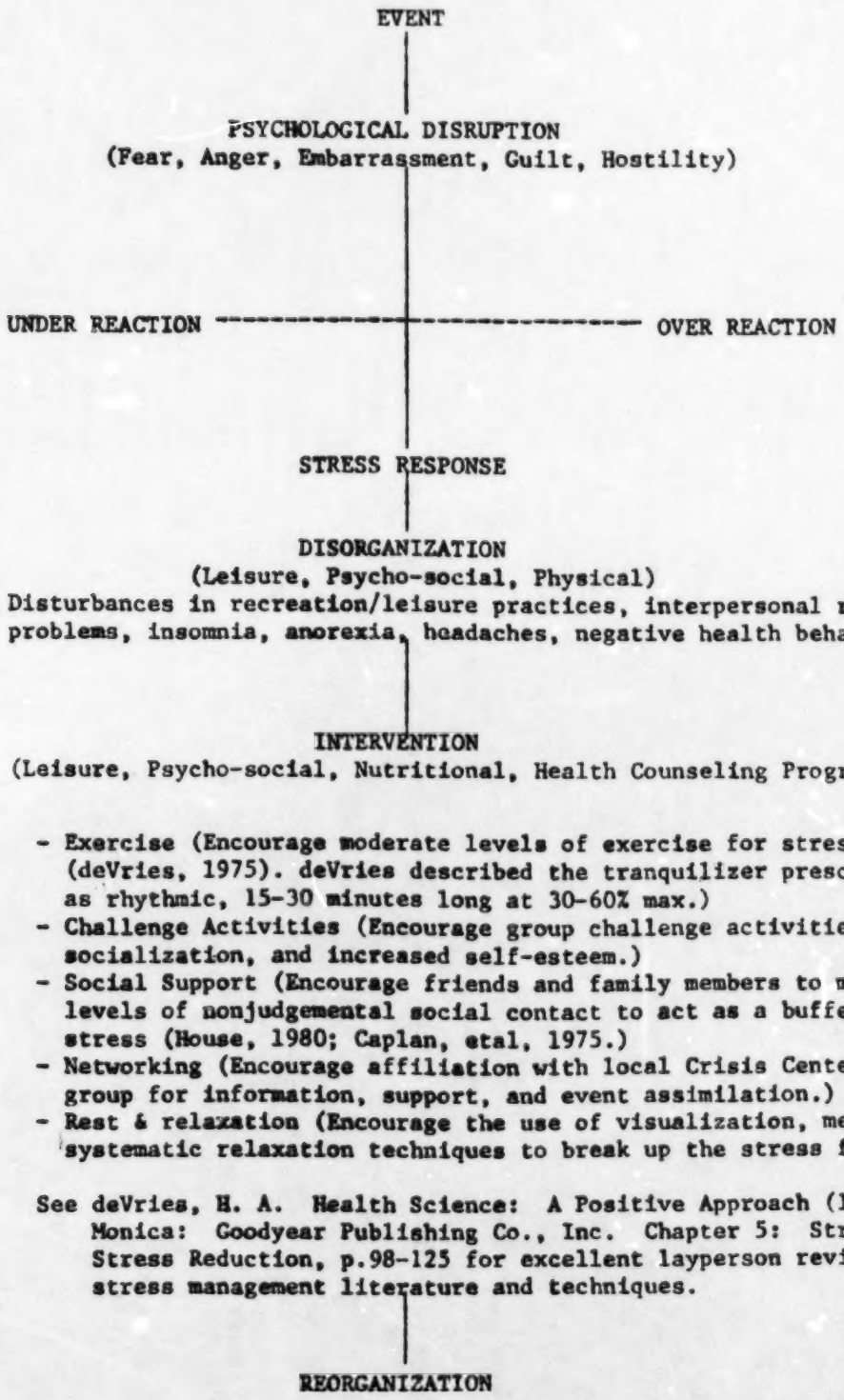
Mean Score Comparisons on Cornell Medical Index for Reorganized and Disorganized Sexual Assault Victims

Item	Assault Status			
	Reorganized	Disorganized	F	P
N	30	21		
%	58.84	41.16		
Present Illness Symptoms				
$\bar{X}$	16.73	38.66	61.16	.001
SD	5.40	14.00		
Past Illness Symptoms				
$\bar{X}$	2.73	4.33	6.39	NS
SD	1.07	2.81		
Personal Leisure Behavior				
$\bar{X}$	1.27	2.38	19.36	.0001
SD	.94	.80		
Social Leisure Behavior				
$\bar{X}$	1.13	2.48	24.41	.001
SD	.97	.93		

$\bar{X}$ = mean

SD = standard deviation

Figure 1: Crisis Framework for Sexual Assault Event


EVENT
PSYCHOLOGICAL DISRUPTION
(Fear, Anger, Embarrassment, Guilt, Hostility)
UNDER REACTION
OVER REACTION
STRESS RESPONSE
DISORGANIZATION
(Leisure, Psycho-social, Physical)
Disturbances in recreation/leisure practices, interpersonal relations problems, insomnia, anorexia, headaches, negative health behaviors
INTERVENTION
(Leisure, Psycho-social, Nutritional, Health Counseling Programs)
- Exercise (Encourage moderate levels of exercise for stress reduction (deVries, 1975). deVries described the tranquilizer prescription as rhythmic, 15-30 minutes long at 30-60% max.)
- Challenge Activities (Encourage group challenge activities for teamwork, socialization, and increased self-esteem.)
- Social Support (Encourage friends and family members to maintain high levels of nonjudgemental social contact to act as a buffer against stress (House, 1980; Caplan, etal, 1975.)
- Networking (Encourage affiliation with local Crisis Center or Womens group for information, support, and event assimilation.)
- Rest & relaxation (Encourage the use of visualization, meditative or systematic relaxation techniques to break up the stress feedback loop.
See deVries, H. A. Health Science: A Positive Approach (1979) Santa Monica: Goodyear Publishing Co., Inc. Chapter 5: Stress and Stress Reduction, p.98-125 for excellent layperson review of stress management literature and techniques.
REORGANIZATION

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Emilyn A. Sheffield, Alex Waigandt, & Deborah Miller

ABSTRACT:

There has been little research on the emotional and physical consequences of disaster. Therefore, this exploratory study was designed to determine if victims of sexual assault differed from nonvictims on dimensions of perceived health status. Additionally, the leisure behavior of adapting and maladapting sexual assault victims was compared. After subjects were matched on the variable of age, the data was derived from 102 respondents, 51 assault victims and 51 nonvictims. Data were generated from the subjects' responses to a demographic questionnaire accompanying the Cornell Medical Index Health Questionnaire (CMI). In a subsequent analysis the postrape leisure choices of the sexual assault victims were examined. Sexual assault victims were categorized as reorganized or disorganized. Reorganized victims reported more positive leisure behavior than did maladapting victims. Programatic and administrative implications were developed from the data.

FINDINGS:

The major findings were: 1) Sexual assault victims were similar to nonvictims demographically except for two exceptions (they had more children and they made more visits to the doctor per year). 2) Sexual assault victims responded more frequently to items related to present illness symptoms, negative health behaviors and female reproductive system illness symptoms. 3) Sexual assault victims with fewer maladaptive responses were more inclined to take time for exercise, rest, and relaxation. 4) Sexual assault victims with fewer maladaptive responses were more inclined to find time to see friends and go out. 5) No difference was found between the victims and nonvictims regarding family health history and past illness symptoms. 6) No difference was found between reorganized (adapting) and disorganized (maladapting) sexual assault victims regarding past illness symptoms.

NOTE:

This presentation focused on the educational opportunities for health and leisure professionals. Programatic and administrative implications of the data were discussed. A model of desirable health and leisure coping strategies for use by educators and counselors was prepared (see next panel). Suggestions for use of this data to enhance administrative support were covered.

TABLE 1: Mean Score Comparisons on CMI (Victims & Nonvictims)

Item		Assault Status Victims	NonV	t	P
N		51	51		
Present Illness	X	20.15	11.98	5.51*	.01
	SD	8.05	6.90		
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Nega. Hlth Bhv	X	2.37	1.12	5.05*	.01
	SD	1.42	0.99		
Rep. Phy Symptoms	X	4.67	2.25	6.20*	.01
	SD	2.13	1.78		

TABLE 2: Mean Score Comparisons on CMI (Reorganized & Disorganized)

	Assault Status Reorg.	Disorg.	F	P
N	30	21		
Present Illness	16.73	38.66	61.16*	.001
	5.40	14.00		
Past Illness	2.73	4.33	6.39	NS
	1.07	2.81		
Personal Leisure	1.27	2.38	19.36*	.0001
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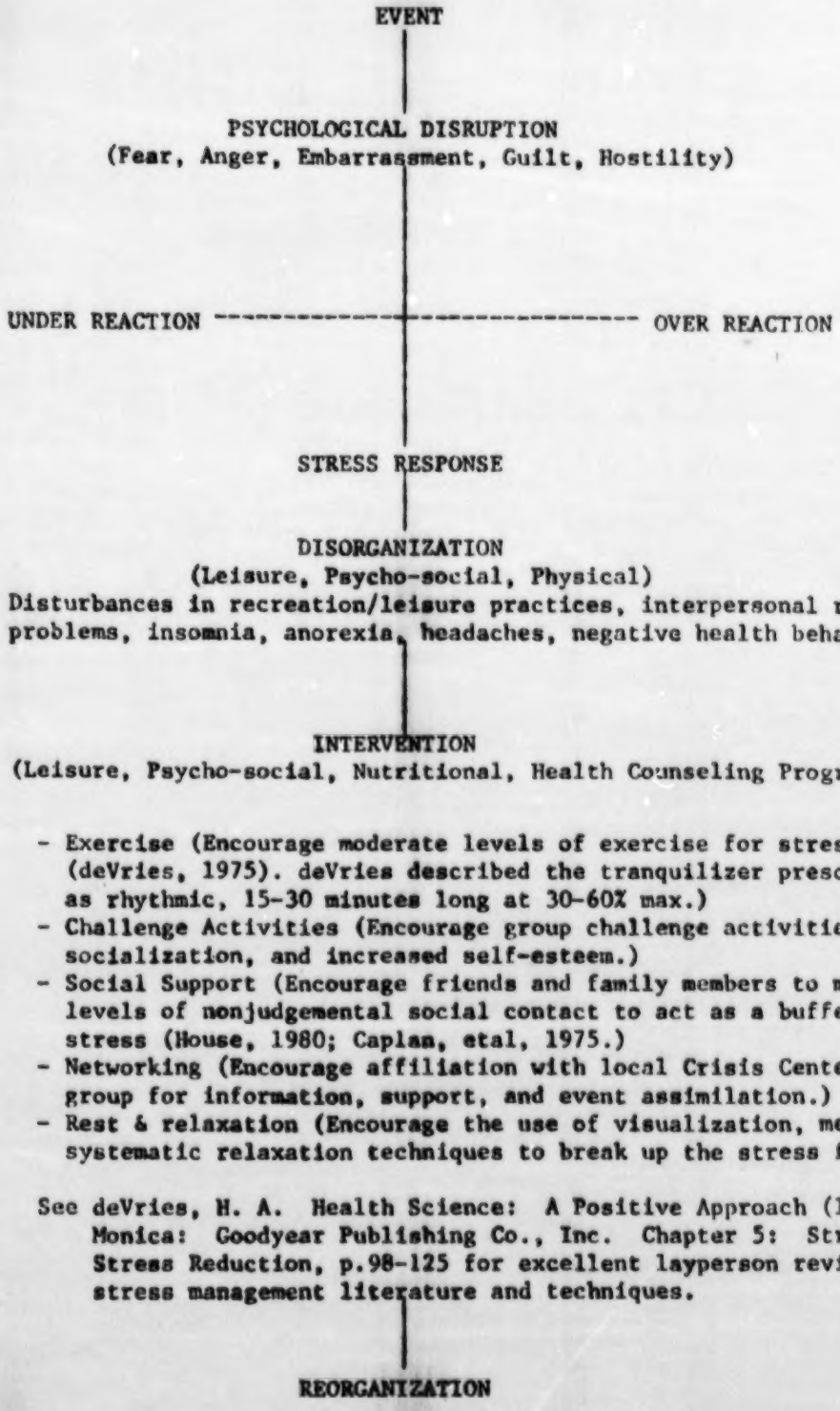
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